Clark County Children's Mental Health Initiative
Clark County, Washington
September 29–October 1, 2003

I. Background

A. *Details of the Site Visit*

The third system-of-care assessment site visit to the Clark County Children's Mental Health Initiative (CMHI), also referred to as the Community of Care, took place on September 29–October 1, 2003. A team of two ORC Macro site visitors conducted a total of 26 interviews with representatives of the system of care, including the project coordinator, members of the governance council, representatives of public child-serving agencies, family advocates, direct service providers, staff responsible for grant evaluation and quality review, and caregivers whose children and families have been served by CMHI.

Site visitors also reviewed randomly selected case records of children enrolled in various programs within the CMHI. The case records provided additional data on the progression of children and families through the system of care.

The following report is based on information obtained from the system participant interviews, case record reviews, and additional documentation provided by grant community staff. The report is organized into five sections:

- Background of the project
- A description of the system of care at the infrastructure level
- A description of the system of care at the service delivery level
- System of care strengths and challenges
- Sustainability efforts and lessons learned

B. *History and Background*

As a result of legislation passed in 1989, responsibility and accountability for mental health services in Washington State shifted from the State-level to county-based entities called Regional Support Networks (RSNs). The RSNs administer the State mental health funds to provide mental health services for individuals receiving Medicaid and others with low incomes. In southwest Washington, the Clark County RSN administers the mental health dollars and contracts with community mental health providers under the auspices of the Clark County Department of Community Services (DCS). In addition to mental health services, the Clark County DCS oversees drug and alcohol treatment and prevention, services for individuals with a developmental disability, housing, community action programs, and youth and family services.

In April 1998, the Clark County DCS applied to the Center for Mental Health Services (CMHS) for a grant to fund enhancements to its existing system of care, to further develop a

comprehensive, integrated system of care for children with severe emotional disturbance. Emphasis was placed on infrastructure development and implementation of the concepts of Individualized and Tailored Care (ITC) and the "wraparound" approach to service delivery. The grant application was approved for a period of 5 years, effective September 1998. Since that time, CMHS added an additional year to allow each grantee a 1-year planning and 5-year implementation period.

As a result of the efforts in Clark County, the Washington State legislation passed the *Engrossed Substitute House Bill 2574* in March 2002 to establish demonstration sites, that when implemented, will strategically support the children's system of care statewide.

Now beginning its sixth year as a CMHS grantee, the Clark County CMHI continues to support the vision of building and sustaining a community of care for children and their families.

Catchment Area and Target Population

The catchment area for CMHI is all of Clark County, located in southwestern Washington along the Columbia River and bordering Oregon. Based upon U.S. Census Bureau data for 2000, the total population in Clark County is 345,238. According to DCS, approximately 16 percent of the population is covered by Medicaid. The minority population documented by the 2000 census is less than 10 percent; however, that figure does not include approximately 20,000 Russians and other Eastern Europeans classified as White.

The CMHI targets children, including adolescents, and their families who have or who are at risk of developing a serious emotional disturbance.

Evaluation data provided by Portland State University (PSU) covering the period from March 2002–September 2003 indicate that 701 children were served by the system of care. Of these children served, the average age of youth was 11.9, of which 62 percent were male; the family median income range was $15,000–$20,000; 85.2 percent of the population served were White and 5.7 percent were African-American. Approximately 6.8 percent of the children and youth served were Hispanic.

Funding

For the current fiscal year (September 1, 2002–August 31, 2003), funding from Clark County's CMHI flows from several Federal, State, and local sources. These include:

Medicaid	$3,522,153
CMHS	$1,470,754[1]
Clark County Juvenile Department	$1,313,951
Child Welfare Services	$ 93,949

[1] This includes a carry-over of $34,997 from the prior year.

Funds that are pooled come from the Juvenile Department, Child Welfare, and Medicaid as outlined above. A total of $71,667 was dispensed through flexible funding budgets. Professionals and parent partners can submit flexible fund requests to a committee consisting of at least three members for approval.

Managed Care

In 1995, Washington State was granted a 1915(b)(1) Medicaid waiver to enroll Medicaid recipients in Prepaid Health Insurance Plans (PHIPs), in effect replacing the previous fee-for-service program with a managed care system. Mental health services for Medicaid recipients are carved out in this waiver. In Clark County, these benefits are arranged through the Clark County RSN, which entered into a full risk, inpatient and outpatient mental health services contract with the State's Medical Assistance Administration. The County is also responsible for providing or arranging mental health care for residents who are not covered by Medicaid, but who otherwise meet the eligibility criteria of the CMHI. The mission of the Clark County RSN is to promote mental health and ensure that residents of the Clark County region, who experience mental illness during their lifetime, receive treatment and services so that they can recover, achieve their personal goals, live, work, and participate in their community. The Clark County RSN is now in its tenth year of operation as a PHIP.

With respect to the CMHI, the Clark County RSN continues to see its role as "a quality overseer"—one of assessing the affects of managed care in relation to the quality of care delivered to children and their families. Performance-based contracting with mental health providers has been developed as a result. Providers are incentivized for improvements in family satisfaction, demonstration of the system-of-care principles, and performance on the various child outcome measures. Contracts with the RSN require that service providers demonstrate that 60 percent of mental health services have been provided in the community versus the clinic setting, and that nontraditional services such as art therapy, recreational programs, camps, mentoring and parent partnering should be reimbursed.

II. Description of the System of Care at the Infrastructure Level

A. Governance

At the time of the system-of-care assessment in March 2002, the Clark County CMHI was in the process of reorganizing its governance structure. No longer a two-tiered configuration (formerly comprised of a Board of Trustees and a Board of Directors), the new streamlined structure is a single advisory body and systems planning entity referred to as the Community of Care Advisory Council (COCAC). The mission of the new COCAC aligns with the former System of Care Policy Council structure which is to build and sustain an effective system of care in Clark County within four distinct domains: resources, structure, process, and community.

Under a new set of bylaws, the COCAC is currently a 17-member board with broad-based representation from of all segments of the mental health service delivery continuum for children with severe emotional disturbance and their families. Appointed positions include senior

executives from public child-serving agencies such as the State Division of Child and Family Services (DCFS), Clark County Juvenile Court, the Department of Community Services, the Battle Ground School District, and a County Commissioner. Community representatives include the Association for Retarded Citizens (ARC) of Clark County, special education staff from the Evergreen School District and the Impact Project of the Vancouver School District, and the Young Men's Christian Association (YWCA). There also are seven community and family member positions, and as of April 2003, a change in bylaws requires that two of these positions be held by youth representatives.

There are two key standing committees of the COCAC. The first is the Family Action Committee (FAC). The FAC was created to capture greater family voice for parents of children with serious emotional disturbance. The FAC is responsible for encouraging community participation and input to strengthen the system of care, to define the common barriers experienced by families, and to explore ways to improve services. The Resource Management Committee serves as the second standing committee. Its function is to review all CHMI activities and projects, and make recommendations for sustainability and for leveraging system collaboration and funding.

The COCAC meets monthly from 6:00–7:30 p.m. on the first Thursday of the month. The FAC and the Resource Management Committee each meet monthly also. Food and childcare are provided for participants at the meetings. The COCAC holds public meetings on a quarterly basis.

B. Management and Operations

Under the direction of the Clark County DCS, the Clark County RSN continues to have responsibility for the day-to-day administration of the CMHI grant. This responsibility includes staff support to the COCAC, oversight of grant-funded staff and mental health contractors, and oversight role with management of the Children's Flexible Trust Fund. The Children's Flexible Trust Fund is a discretionary fund to be used for individualized needs of CMHI children and their families. Policies and procedures for accessing these funds were developed by the previous Board of Directors' Finance Committee and have been operational since August 2001.

Staffing Structure

Grant-funded positions for the CMHI include staff who are part of the operations team within the Clark County DCS, as well as staff who are affiliated with CMHI through its various partnership projects and key contracted service providers. These relevant groups are described in greater detail in Section III below.

Clark County RSN/DCS

The grant is managed and operated through the following individuals within DCS and the RSN. The number adjacent to the positions reflects the number of persons with this title and not the relative FTE equivalent.

director (1)
deputy director (1)
special project coordinator CMHI (1)
family support specialists (5)
family resource specialist (1)
mental health disability liaison (1)
family information specialist (1)
Community Empowerment Project (2)
care coordinator supervisor (IV–E Project) (1)
administrative assistant (1)
special projects manager (1)
finance analyst and manager (2)
contract manager (1)
information system specialist (1)
data clerk (1)
consultant (1)
youth project coordinator (1)
care coordinators (2)

Connections Project Connections is a blended funding partnership among the Juvenile Court, CMHI, the County RSN. The grant contributes $250,000 of the $1,000,000 total funding with the majority of the funding coming from Juvenile Court general funds and tax dollars. The combined dollars fund four probation counselors, four care coordinators, four probation associates, and four family specialists. Teams comprised of representatives from each of these four different staff positions work with each youth and his or her family.

Catholic Community Services Clark County has contracted with Catholic Community Services (CCS), a not-for-profit service organization, to provide both crisis stabilization services and intensive wraparound services to children served by the grant. The grant funds the director, 2 intensive resource managers, 11 care coordinators, 4 family therapists, three family partners, 4 family support specialists, and 1 foster care licensor.

Parent Partners The CMHI established a pool of parent partners who are parents and caregivers of children with emotional and behavioral challenges. Parent partners support other parents through active listening, systems navigation and identification of community resources. They receive a stipend of $15 per hour. As of the time of the site visit, CMHI funded 22 parent partners.

Minority staff representation has increased significantly since the 2002 assessment and now includes Russian, Hispanic, Laotian, Cambodian, African-American, and Native American individuals, some of whom are bilingual.

Training

The CMHI has continued to offer many training activities on facets of family-focused care, cultural competence, individualized care, consultation, and community action. Training sessions have been available for grant-funded staff, families and child-serving agencies. Parent partners meet on a monthly basis for training on family-focused values, and the school system has been more involved in family-focused issues training during the past 18 months. Wraparound training programs have been a large focus for mental health and juvenile justice staff.

During the past 18 months, the Community Empowerment Project has been added to provide training, advocacy and technical support to parents of children with complex needs. Dedicated to *Strengthening Clark County–One Family at a Time*, the Community Empowerment Project

trained over 240 people in its first year. Evaluations of these training experiences demonstrated high levels of satisfaction using this approach.

C. Service Array

All grant-required services[2] are present in the CMHI service array. Additional services include mentoring and tutoring, transportation, drug and alcohol counseling, skills-building activities, and parent and youth advocacy. Previous concerns expressed about the adequacy of respite care and therapeutic foster care services are being addressed through the FAC. For example, this committee sponsored a Family Forum on Respite Care, and recommendations were forwarded to the COCAC in the early part of 2003.

Children and their families continue to have access to the three historic mental health service providers in Clark County: Columbia River Mental Health (CRMH), the Children's Home Society, and the Children's Center. As the crisis stabilization provider, Catholic Community Services (CCS) also continues its role in providing intensive wraparound services that are modeled after system-of-care values. Even though child and adolescent mobile crisis services still are available, they are no longer provided through Peace Health Behavioral Healthcare but through CRMH.

As a part of the children's mental health redesign in Clark County, several new mental health provider contracts were signed to expand capacity for crisis stabilization and suicide prevention. Clark County also received Federal funding for a Youth in Transition Program to develop models for supporting youth as they transition into adulthood. This includes addressing completion of high school, vocational education, employment, independent living, social adjustment and cultural competency, for example.

Family Resource Centers (FRC) still are in place to offer education, social opportunities and access to community-based supports to families. Services offered may include childcare, health service, early childhood education, parent education, recreational programs and workforce development. There currently are seven FRCs operating in Clark County.

Support services for youth continue to be added to the service array through the programs of the Clark County Youth Commission and Youth House. The Youth House is designed to provide a physical space for youth and youth-driven organizations, for the purpose of supporting youth empowerment and youth and adult partnerships. In response to an increase in youth suicide, and suicide attempts and threats, the county created a Youth Suicide Prevention Task Force. This group developed a prevention plan for the community that was presented to the county commissioners in February 2002. The plan focused on increasing community awareness about suicide, enhancing school-based prevention programs, training on suicide prevention, and improving access to mental health services including an enhanced 24-hour response to crises. As

[2] Services required in the grant's guidance for applicants include diagnosis and evaluation; case management; outpatient individual, group, and family counseling; medication management; professional consultation; 24-hour emergency; intensive home-based; intensive day treatment; respite; therapeutic foster care; and transition-to-adult.

another means of leveraging dollars to support youth programs and services, the Clark County RSN also has created a Youth Foundation and started a Teen Talk Line that is run by volunteer youth.

D. Quality Monitoring

There are two groups with primary responsibility for program evaluation and quality monitoring: the Regional Research Institute for Human Services at PSU and the Clark County RSN Quality Management Department. In compliance with grant requirements, PSU was designated as the external evaluator over the life of the grant and continues to contract with the State for services relating to the CMHS national evaluation. PSU gathers and analyzes data obtained from agencies and providers, conducts focus groups, and administers interviews with caregivers and children. Particular evaluation activities include assessment of child and family functioning outcomes, caregiver strain, family and youth satisfaction, organizational and system-level assessment of wraparound, social network (interagency) analysis, juvenile justice recidivism rates, youth in transition barrier assessment, community involvement, drug use, and focused evaluations of each of the CHMI wraparound projects. Findings are presented quarterly to the COCAC, to system stakeholders via a monthly *Children's System of Care Data Report* newsletter, and at national meetings on the children's system of care program. Outcome data, when available, are utilized to improve service delivery. Satisfaction surveys also are used as a barometer to inform program administrators of program effectiveness.

The Quality Management Department within the RSN has accountability for meeting quality review requirements of Washington State code. In particular, a Quality Management Team of consumers, providers, and child-serving agencies reviews the quality of care and services delivered to both children and adults in the county. PSU and the RSN have established a more formal relationship since the time of the 2002 assessment in order to create greater synergy in identifying and reporting on system-wide performance issues.

III. Description of the System of Care at the Service Delivery Level

A. Entry into the Service System

The process of entry into the CMHI system of care has remained constant over the past 18 months. Children still are screened and assigned an intensity level at the time of referral and intake. This intensity-based triage process is dictated by whether the child is in crisis or not. Upon this determination, the child is placed then into a wraparound project that best meets the child and families situation.

Assignment of Intensity Levels

There are essentially three levels of mental health care services within Clark County's CMHI. These levels are universal, targeted, and intensive.

Universal mental health services are brief to moderate in duration and have limited involvement with other child-serving agencies. The average duration of system involvement is approximately 3 months, with a minimum of 6–12 visits for assessment, counseling, therapy, or medication management. Families access universal services directly by means of self-referral or referral from another child-serving agency.

Targeted mental health services extend beyond basic clinic-based therapeutic intervention. Children and families in this category need more intensive services with greater flexibility in the time and location of services provided. Targeted services tend to be community-based and family-focused.

Intensive mental health services are designed for children and their families who have experienced a recent inpatient psychiatric treatment and who require high intensity services and lengthy service duration. These children have the greatest risk of out-of-community placement, have severe behavioral disturbance with moderate to severe functional impairment, and typically are involved with one or more child-serving agencies such as juvenile justice, child welfare, substance abuse, and the schools. Services needed include wraparound and crisis respite. Universal services are provided by the three historic mental health service providers in Clark County: Columbia River Mental Health, Children's Center, and the Children's Home Society. Targeted services are provided by the same three providers, as well as by Family Solutions. The intensive services are provided solely by CCS.

Wraparound Projects

The approach to service planning and the wraparound team involved are dictated by which child-serving system referred the child and family and the service level of intensity needed.

Since the 2002 assessment, strengths-based wraparound projects have been put in place within the juvenile justice system (Connections), the school systems (four School Proviso Projects), and child welfare (Title IV–E), as well as the intensive wraparound services provided by CCS. Each of these is briefly described below:

Connections Project. Connections, a blended funding partnership between the Juvenile Court and CMHI, is a strengths-based program for probationary youth with behavioral health issues. Through application of the system-of-care principles, it is designed to deter youth from continued criminal activity once court-ordered supervision expires. Moderate and high-risk youth on community supervision will be considered for the program. Probation counselors will make the referral for youth who have a diagnosed behavioral health disorder, score of 1 or greater on the Risk Assessment Section 8 Mental Health, and who are residents of Clark County.

School-Based Mental Health Programs. There currently are five school-based mental health projects in operation. These projects have blended funds between mental health and the school system to support the community-based, individualized wraparound approach to service delivery. Each team has a Peer Parent Supporter (parent advocate) and either a Family Resource Specialist (care coordinator) or Child Intervention Specialist

Title IV–E Waiver Demonstration Project. Clark County has an agreement with the State Division of Child and Family Services (DCFS) to blend funds to support services for youth eligible for public mental health services who are at risk of out-of-home placement. Services will be planned and provided according to the concepts of Individualized and Tailored Care using a child and family team structure.

Referral

Children are referred to the CMHI from a variety of different child-serving agencies including the school system, juvenile justice, mental health and substance abuse providers, child welfare, foster care, and the developmental disabilities administration. Most crisis referrals to CCS come from Southwest Medical Center. For children and families not in crisis, the referral call is placed to one of the three historic mental health service providers named above. Essentially anyone can make a referral into the system of care, including families and other community-based individuals or groups.

If it is determined by mental health intake screening that the child needs targeted or intensive mental health services, then the child and family is referred to CRMH or CCS for further evaluation and for referral. For the child in acute crisis, there is a 24-hour, 7-days-per-week Clark County Crisis Line with coverage by mental health professionals. When the family contacts this number, a therapist immediately speaks with the family. If the child is a potential harm to self or others, the family is promptly referred to the Children's Mobile Outreach Team (CMOT). The CMOT then takes one of the following four actions: contact the family by telephone, make a home visit, meet the family at a location of their choice, or meet the child and family in the emergency room, if that is where the child is located at the time. Upon evaluation, the child is referred by CMOT for targeted or intensive services.

The process from referral to first contact may be less than 24 hours in instances where the family needs targeted or intensive services. Respondents noted that CCS makes a crisis contact for intensive services within 1 hour of referral, and within 24 hours for children needing targeted services. With both types of interventions, the completion of paperwork and a detailed intake does not occur until the crisis has stabilized and the first child and family team meeting has been held, usually within 1–2 weeks.

In addition to the standard eligibility requirements for children and families to receive services under the CMHI grant program, eligibility for services varies somewhat according to the provider providing the services. For example, Connections only serves children who are currently on probation with juvenile justice; CCS only serves children enrolled in Medicaid; and the VI–E demonstration project only serves children at risk for out-of-home placement by child welfare.

Outreach

As a result of a variety of outreach efforts in the community, the CMHI has increased the number of children and families served since the 2002 assessment. For example, quarterly public meetings including presentations on progress made, reports from family groups, and recognition

of local contributors are advertised in local newspapers and targeted to families. Also, at the beginning of each school year, the CMHI conducts focused outreach to schools. Furthermore, the Community Empowerment Project provides training to families concerning how the child-serving systems operate.

B. Service Planning

The venue for the service planning process is the Child and Family Team meeting, at which children and families participate with other team members to create an individualized and tailored plan of care known as a "Family Support Plan" or "Individualized Service Plan." Accountability for service planning rests with a care coordinator, who may have a different title based upon the wraparound project assigned. The care coordinator role is to assure that planning, coordination, and implementation of the system-of-care approach follows accepted procedures.

Another key team member in both service planning and provision is the peer parent supporter, or "parent partner." The role of the parent partner is to ensure that there is an advocate for the family who can help them navigate the mental health care system. The parent partner is an individual who either has had or currently has a child with severe emotional disturbance receiving mental health services. Each family is assigned a parent partner as well as a care coordinator.

Wraparound team meetings initially are held weekly, then become monthly once the service plan is developed. Meeting locations vary depending upon the program providing care coordination. Service planning teams always include the family, care coordinator, parent partner, therapist, and the relevant agency representative. The child or youth also participates whenever possible and appropriate.

The wraparound service planning process begins with convening the child and family team. The purpose of the planning meeting is to help the family decide who should be added as members of the team, to conduct a "strengths chat" with the child and family (and in some cases, other team members), and to develop the individualized and tailored care plan. The development of the care plan is a central component of the wraparound service planning process. Serving as the team facilitator, the care coordinator works with the child and family to elicit needs and strengths across a series of nine domains, which include education, recreation, finance, safety, and cultural beliefs.

The typical care coordinator to child ratio varies among the wraparound programs. Care coordination through CCS is the most intense with a ratio of 1 to 5, whereas school system ratios range between 1 to 5 and 1 to 9, and IV–E Program ratios average 1 to 9. Connections has four staff members on each team (care coordinator, probation counselor, probation associate, and family specialist or parent partner) that serves a total of 25 children and their families.

C. Service Provision and Monitoring

The CMHI reports broad flexibility in times and locations for service delivery. Many services are available during evening and weekend hours, and RSN provider contracts require that 60 percent

of services be provided outside of agency offices. Care coordinators from the different agencies, therapists, and other providers commonly meet children and families in homes, schools, juvenile court, and elsewhere in the community. Services are delivered to children and families based upon the results of the strengths chat and the individualized and tailored care plan. Care coordinators, parent partners, and other wraparound team members collaborate to find the services needed by individual children and families.

The processes and activities related to children and families' receipt of services is coordinated and monitored through the care coordinator and documented in the child's service record by the relevant service providers. Wrap team meetings are held on a monthly basis to evaluate the effectiveness of services provided. In addition to these meetings, the care coordinator and parent partners conduct follow-up with families via telephone or in person to assess progress, do status checks, ensure services have been delivered, and assess family satisfaction. The frequency of these kinds of follow-up activities varies from weekly to daily, depending on the nature of the child and family situation.

D. Case Review

There are two committees providing case review services for Clark County—the Children's Long-Term Inpatient Program (CLIP) and the Community Partners Committee.

The CLIP is a committee consisting of representatives from Behavioral Health Services, DCFS, and other community agencies, which reviews cases involving children being considered for long-term residential psychiatric treatment. Its tasks include determination of whether less restrictive, community-based services are appropriate and development of interim and long-term strategies for supporting children in these least restrictive settings. This committee meets as needed and reports to the COCAC on a quarterly basis.

The Community Partners Committee consists of representatives from public child-serving agencies and from private providers. It also includes two family representatives. The committee is available to assist children and families access community programs and services, identify resource gaps, develop services to assure least restrictive placement, and ensure individualized, strengths-based service planning. This committee meets monthly during the day and once again during the evening, if needed.

Although any agency, organization, provider, or family member may refer a case situation to the Community Partners Committee, most referrals come from mental health agencies or the Connections program. Self-referrals are also common. All referrals go first to the committee chairperson, who telephones the primary caregiver to further identify the child and family's needs and to determine whether review by the committee is necessary. Some families' needs are quickly met by resource suggestions from the chairperson during the telephone conversations. However, children receiving wraparound services through CCS, Connections, school programs, or the IV–E program commonly are referred by care coordinators once the need for committee review is clearly identified.

Since the 2002 assessment, approximately a half dozen children served by the grant have had their situations reviewed by the Community Partners Committee. The discussion at meetings is focused on exploring service options to meet the child and family's needs that are both community-based and least restrictive.

After the meeting, the family receives a list of the service suggestions made, along with the names and telephone numbers of individuals who agreed to perform specific actions to help the child and family. Family satisfaction surveys are conducted immediately following the meeting and again a few months later. The committee hears reports of each child and family's progress at the next several monthly meetings.

IV. System of Care Strengths and Challenges

The following section outlines CMHI's strengths and challenges as they relate broadly to infrastructure and service delivery. The term *challenges* is used in a broad sense to identify areas in which the program has not yet made any efforts, or is still in the early stages of development, as well as areas that have been difficult to implement, or in which system-of-care principles have not been successfully achieved.

A. Family Focused

Strengths at the Infrastructure Level

- Respondents continue to report active family involvement in the governance of the CMHI and its related activities. In addition to the bylaws changes to include family and youth slots, the FAC is evolving in its role as the conduit for inclusion of family voice in governance decisions. For instance, through this committee, up to 100 families were interviewed about their perceptions and experiences with respite care in the County and their recommendations sent to the COCAC. Respondents stated that as a whole, family members are respected and their input valued.

- There is uniform agreement that COCAC meeting times and locations are convenient for families.

- While food and childcare are provided to facilitate family participation in meetings, there were differing opinions regarding whether stipends for transportation, attendance, and other assistance actually were provided.

- The Community Empowerment Project has strengthened training programs on family-focused care. This program was created based upon family input and addresses the training and access needs of families. Parent partners receive monthly trainings, and cross-agency sessions for staff are held on a quarterly basis.

- Families are part of the CMHI staffing structure and serve to support families in the care of their children. The pool of parent partners provided though the RSN has grown to over

20 individuals. There is a parent partner role present in every wraparound child and family team meeting and in all mental health centers.

- Family involvement in grant program operations is significant and includes participation in recruiting and hiring of staff, training of providers and families, operating the FRCs, and serving on committees and in management meetings.

- CMHI has mechanisms in place to ensure that there are family support functions in the service array. The Community Empowerment Project's role in advocacy and technical support, the Parent Partners Program, the FRCs, the inclusion of family advocacy within each wraparound project, parent support groups and skill building programs, and the FAC are indicative of these efforts.

- Information from outcomes data is collected and analyzed as part of the national evaluation, and is used to identify service barriers and improve service delivery. The enhancements to the Parent Partners Program were a direct result of data showing that caregiver strain and stress are reduced with parent support. The need for additional respite services was also identified and brought to the attention of COCAC.

- Family involvement also is evident in quality monitoring. Parents continue to be an integral part of the PSU evaluation team. Family members stationed at PSU participate in the development of survey instruments, data collection and analysis, coordination and conduct of interviews, providing reports to stakeholder groups, and participating as presenters at State and national system-of-care conferences.

Strengths at the Service Delivery Level

- According to most respondents, entry into the CMHI is efficient and family-friendly. Families are contacted within one hour for crisis care. Children needing other services are contacted within 1–2 days of referral to schedule the first child and family team meeting. However, one respondent did mention a family who felt that people did not listen carefully to the parents' concerns.

- The service planning process emphasizes family involvement throughout. Planning meetings generally are held only when family members can participate, although some child custody cases do not always have family members present. Family members are treated with respect, encouraged to take an active role in development of service plans and subsequent evaluations, and invited to bring support persons to meetings. However, there were some concerns expressed about families not always feeling they had full choice of services.

- Strengths and needs reportedly are assessed for each child and family, and are incorporated into service plans. Service plans are monitored aggressively by care coordinators and wraparound teams, and services planned generally are provided.

- Respondents agreed that service providers include caregivers in the provision of services. Families are kept informed of their child's progress and are encouraged to express opinions and offer suggestions. Examples were given of therapists and parent partners planning activities that included family members along with the child.

- Service providers reported several examples of the successful incorporation of family strengths into service provision, such as helping the parent enroll in education and training programs or providing financial assistance so families could participate together in outdoor activities or sporting events. Case records reviewed also demonstrated use of family strengths in the provision of services.

- The Community Partners Committee meets monthly to assist children and families identify and access community resources, whenever such assistance is needed. Respondents agreed that this committee is family-friendly, providing pre-meeting orientation, the support of parent partners at the meeting, and emphasizing that the family is "in charge" of a child's care.

Remaining Challenges

- With respect to the COCAC, consistent concerns were expressed about the level of family participant turnover in recent months. Also, it was stated that the COCAC is not always the best place to bring "single" issues or specific needs.

- Several respondents voiced concern that parents are not aware always of the services that are available to them. For example, parents feel that sometimes a child has to be arrested or sent to the emergency room before help is provided.

- It is evident that family satisfaction is assessed and data examined; however, respondents were not able to articulate whether service system changes had been made as a result of these findings.

B. Individualized Care

Strengths at the Infrastructure Level

- The management and operations of the grant fully supports the process of individualized care. Provider contracts require that services be provided through a process of Individualized and Tailored Care. There are best practice standards in place for performing wraparound, and flexible funds are provided through the Children's Trust fund. Children's case records also are audited to determine compliance with the provision of individualized care.

- CMHI offers extensive staff training in the concepts of individualized care, including presentations by nationally recognized experts on wraparound.

- CMHI continues to improve its involvement of youth in the planning and provision of services. Bylaws now require two youth participants on the COCAC, and the Youth House and its many programs provide the forums for youth voice in the system of care. Children are encouraged to participate in identifying their strengths and needs, choosing services and providers, and in identifying individuals to accompany them to meetings for support. Many children also have mentors.

- Respondents indicated that CMHI's service array includes all grant-required services, plus additional traditional and nontraditional supports.

- There are many mechanisms in place to monitor the effectiveness of services and child functioning outcomes through the national evaluation, through PSU, and through the Clark County RSN's quality monitoring program. Children in the CMHI have shown improved functioning and increased strengths from intake to 6 months follow-up. Data also demonstrate that caregiver participation in service planning is related to child improvements.

- PSU is closely monitoring outcomes associated with Connections. The data demonstrate that Connections youth strengths are improving faster than the "general" wraparound population. PSU also is working closely with the RSN and juvenile justice to capture data on youth recidivism rates.

Strengths at the Service Delivery Level

- Individualized Family Support Plans, also called Individualized and Tailored Plans, reportedly are developed for all children and families served by the CMHI grant. Respondents agreed that children are engaged actively in the service planning process, to the degree that they are able and willing to be involved.

- Identifying children's strengths and incorporating them into the service plan is accomplished through the strengths chat initially conducted by the care coordinator and then continued during the wraparound team meetings. Respondents and case records provided numerous creative examples of how strengths were used to plan services, such as assigning a mentor who would develop activities based on a child's interest in math or drawing; enrolling the child in a sports program; arranging for a local store to donate a used snowboard so a child and his brother could enjoy snowboarding together; finding a job at a bike shop for a boy who likes bikes; and letting a youth who likes to cook bake cookies for a nursing home as part of his community services obligation.

- Caregivers acknowledged that services planned for their children generally were a good match for the child's needs. However, instances were mentioned in which a child's need for mental health counseling was not included in the plan or where limited choice in services was offered.

- Children reportedly receive all services included in their plans over 90 percent of the time, perhaps less often for children in Connections. Service plans may not be fully

implemented in the following situations: the family moves out of the county; the family does not follow through; the provider does not follow through; the child decides against participating in the service; or service capacity limits the availability of a particular service, such as Big Brothers or specialized daycare.

- According to respondents and a review of sample case records, a child's strengths are used routinely to shape the provision of services as well as the planning of services. For example, a therapist attended confirmation classes with one child who had artistic skills and got permission for the girl to paint a picture for her confirmation project. Another child was taken on nature walks by his therapist, who used the boy's love of nature to teach him self-control as they sat quietly and watched the animals. Other examples of using a child's interests to provide services included teaming a boy with a man who taught him to restore woodwork; giving a good reader the chance to tutor younger children in reading; finding a man who shared a boy's interest in golfing to be his mentor; and helping a child buy the athletic clothing he needed to play on the school team.

- Care monitoring is a primary responsibility of care coordinators and reportedly is accomplished through frequent telephone and face-to-face contacts with families, visiting children at groups homes and at school, telephone and written communications with involved agencies and providers, and talking with participants at Child and Family Team meetings. Monitoring efforts are routinely conducted on a weekly basis, but may be conducted as often as daily, if needed.

Remaining Challenges

- Information on child outcomes and individualization of services is collected, analyzed and used to improve service delivery, though not all respondents could express how these data are used to make system and service delivery changes.

- Involvement of children in the Community Partners Committee is limited. Although respondents agreed that children would be welcome to participate in the Community Partners review meetings, not all children are willing, functionally capable, or available (if in detention or on the run) to participate. There have been instances in which a child attended for the first few minutes of the meeting, if the parent wanted the child to speak to the group.

C. Culturally Competent

Strengths at the Infrastructure Level

- Efforts to create a culturally competent system of care continue to evolve. The Cultural Competence Committee presented a report to the COCAC in April 2003 demonstrating growth in the diversity of the Clark County population. This report outlined the work of the committee since its inception in 1999 and outlined its strategic plan for the coming year. Clinical Practice Standards for Cultural Competency were approved by the RSN's

Quality Management Committee, and community partners were identified to assist CMHI in enhancing the level of cultural competence in Clark County.

- Cultural competence training with national experts has been provided to staff, child-serving agencies, and to families.

- Despite the fact that the majority of the Clark County population is White, the CMHI has been successful in hiring parent partners to match the cultural diversity of the community served. The background of the families receiving services has included Russian, Hispanic, Laotian, Cambodian, African-American, and Native American individuals.

- Few families served by the CMHI have had primary languages other than English. Provider contracts do require, however, that brochures be translated into Spanish, Russian, Vietnamese, Cambodian, and Korean. Some staff members are bilingual in Spanish and Russian, and a network of interpreters has been identified and is available as needed. American Sign Language for the hearing impaired also has been provided.

- Mechanisms are in place to assure that the quality monitoring process is culturally competent. A measure assessing family perceptions of how well staff understand family culture was added to the satisfaction questionnaire. A cultural competence indicator is being incorporated into the RSN's quality management program. Family interviews have been conducted in Spanish, Cambodian, and Russian, and some interviewers are African-American.

Strengths at the Service Delivery Level

- The entry process reportedly has been conducted in Russian, Vietnamese, and American Sign Language. There are also resources available to conduct intake in Spanish and to hire interpreters for other languages, as needed.

- The culture of the child and family is assessed during the initial strengths chat, during wraparound team meetings, and during home visits. Examples of using information about culture to plan services include exploring a biracial child's feelings about his racial background; finding an African-American mentor for an African-American child; assisting parent and child from a poverty culture to navigate the mainstream world; finding someone to take a child from Baptist background to church on Sunday, as the foster family did not attend church; assist a Native American family to get back in touch with their tribe; help an immigrant Hispanic family apply for a green card; and ask a Russian therapist to help collect literature in Russian on social services topics for a Russian family. The review of case records provided additional examples of the assessment and use of culture in planning services.

- Whenever possible, children and families are linked to providers of similar cultural backgrounds. Other examples of ways that providers have used culture to help direct provision of services include meeting with a Native American consultant for advice in working with a Native American family; consulting with a Hispanic parent partner for

advice on working with a Hispanic family; connecting a family with resources about Russian culture so they could be supportive of their adopted Russian son; buying books that reflected African-American culture for grandmother to read to child; and helping children connect with family members in other States and countries who provided a connecting link to the family's culture, including Navajo, Portuguese, and Mexican.

- A few bilingual providers are available who speak Russian, Spanish, and American Sign Language. In addition, interpreters are available as needed during the service planning and service delivery processes.

- Although the need has not yet arisen to accommodate a language other than English at a review meeting, the case review bodies are prepared to provide interpreter services as needed. A private agency in Portland provides interpreters who are familiar with both the language and the subject area of the discussion.

Remaining Challenges

- CMHI staff reported a need for improving the methods by which the cultural background of the children and families served is used to enhance service capacity. For example, staff have difficulty articulating how cultural organizations and community groups are used to help develop the service array, advise providers, or modify existing programs and services to address the cultural needs of the children and families served. Currently, the child and family team meeting is the primary vehicle for cultural assessment, and the RSN offers assistance if the family requests help around a specific cultural issue.

- According to respondents, there have been minimal systems changes as a result of the cultural competence data reviewed thus far. It was noted, however, that PSU is working more closely with the RSN quality manager to determine ways to incorporate national and local data into operational improvements.

- Although the Cultural Competence Committee has developed cultural competence standards to guide CMHI processes, respondents agreed that more outreach needs to be done to effectively reach the growing minority populations of Clark County. Advertisements concerning openings on various committees have been posted in both Latino and Russian language newspapers.

- No attempt has been made to collect information on the cultural diversity of case review group membership.

D. Interagency

Strengths at the Infrastructure Level

- Clark County child-serving agencies actively participating in the COCAC include mental health, juvenile justice, child welfare, and education.

- All agencies executed memoranda of understanding at the inception of the CMHI, however; participation was reported to be voluntary. New State legislation also requires the collaboration and participation of these public agencies when demonstration projects on systems change are implemented.

- Efforts to share administrative processes among the child-serving agencies have improved since the time of the 2002 assessment. Ongoing efforts include jointly developing staff training materials, participating in recruiting and hiring, and holding joint staff meetings. Integration of case records and the development of an integrated Management Information System (MIS) have been more recent successes. Not all respondents on the COCAC were familiar with these efforts.

- There are several mechanisms in place to integrate staff across agencies. Staff report joint training programs, shared staff positions between mental health and the School Proviso projects, Connections, and the IV–E program. Mental health staff also are outstationed at schools, juvenile justice, child welfare, and at emergency rooms for the 11:00 p.m.–7:00 a.m. shift. Along with these efforts, CMHI also has a partnership with Americorps to provide mentoring at the Youth House.

- The child welfare, juvenile justice, and mental agencies participate in blended funding arrangements.

- All child-serving agencies, except health, participate in the quality monitoring process to some degree. All provide data; and juvenile justice, child welfare, and mental health serve on the Quality Monitoring Committee.

- Evaluation staff from PSU are working on a Social Network Analysis project to assess how agencies relate to one another. For example, the analysis will consider referral patterns and meeting attendance at the system and service delivery levels. At this juncture, these data have not been analyzed or used to make changes in the program.

Strengths at the Service Delivery Level

- All public agencies refer clients to the CMHI, but only mental health through the RSNs and juvenile justice through Connections actively conduct intake. However, space is provided for staff to conduct intake at the schools, DCFS, FRCs, and hospital emergency rooms. There has been an increase in referrals from public health through a teen parenting center.

- The core child-serving agencies involved with a child and family (mental health, child welfare, juvenile justice, and school) have routinely participated in service planning. However, respondents noted that child welfare and school personnel are not always involved consistently in the planning process. School personnel will attend team meetings only if they are held at the school.

- Although all agencies are welcome to make referrals for case review, most of the referrals have come from mental health, juvenile justice, child welfare, or the families themselves. Occasional referrals also have come from developmental disabilities and EOC Head Start. All child-serving agencies are involved in the case review process for the CLIP, and the Community Partners Committee has had members from all agencies except for schools.

Remaining Challenges

- Respondents stated that public health and staff from the Medicaid program are noticeably absent from CMHI activities at the governance and service delivery levels. Comments also were made that the schools are not as actively involved as they could be, that two school members were lost this past year, and that it is difficult to keep elected members involved.

- The RSN has contracts with child welfare, mental health providers, the school district, and juvenile justice; however, there are no specific written requirements for participation by these agencies on the COCAC. Participation on this committee reportedly is voluntary.

- All agency representatives clearly articulated the success of the CMHI in helping staff identify and ensure children and family access to programs and services. It was evident that some child-serving agency representatives are not aware of the CMHI's efforts to improve interagency collaboration, such as sharing administrative processes, co-locating staff, and blending funds. When asked about interagency activities, the least informed representatives are those from the schools. Most everyone is familiar with the Connections Program.

E. Collaborative/Coordinated

Strengths at the Infrastructure Level

- Agency staff reported being very satisfied with the processes in place to update them on grant activities. Interagency training sessions, quarterly newsletters, e-mail correspondence, press releases, and a web site all have been effective in communicating information concerning the grant to agency staff and providers. Also, COCAC members serve as conduits for the dissemination of information within their agencies.

- The coordination of services across providers, agencies, and organizations is reported to be very effective as measured by the ability of children to stay in the community for care. Interagency staff meetings, cross-agency systems training, wraparound meetings, and the Community Partners Committee, all are used for this purpose. "Systems Glitch" meetings also are held when families seem to be caught in the middle of decisions between or among agencies.

- Efforts to assess how well services are coordinated are not part of the national evaluation. Respondents reported that RSN has taken an active role in this process. In conjunction with child-serving agencies, the RSN has developed policies and protocols for ensuring smooth transition between providers. A new Service Transition Study is being implemented to evaluate the effectiveness of these practices.

Strengths at the Service Delivery Level

- Outreach efforts to inform other agencies, providers, and organizations about the grant and its services reportedly have been substantial and highly effective. Since the 2002 assessment, DCS hired a public relations expert to help with outreach efforts. Cross-agency training, presentations to partner agencies and providers, and quarterly newsletters continue. The Community Empowerment Project conducts satisfaction surveys for all the training sessions they give, which have shown a 98 percent satisfaction rating. In addition, CMHI staff give annual presentations on systems of care, blended funding, and outcomes to both the local and State legislatures. The upcoming quarterly review to the COCAC will include a 15-foot panel illustrating all the different funding streams that support the CMHI. Outreach efforts reportedly are never complete; however, there is constant turnover of staff in all agencies and provider organizations.

- Most respondents agreed that the providers and organizations involved with a particular child and family frequently participate in the service planning process, although this is not always true for every child and family served. Such participants have included private therapists, sports coaches, youth group leaders, pastors, teachers, mentors, and natural supports from the extended family and community. Occasionally psychiatrists have participated also.

- As a result of collaboration among agencies, organizations, and providers on the wraparound teams, service planning is said to be fairly well coordinated. In addition to the team meetings, care coordinators and other caseworkers frequently attend other service planning meetings such as Individual Education Plan (IEP) meetings, DCFS planning meetings, and juvenile court reviews. However, in spite of efforts to incorporate all agency plans within the team's family support plan, respondents noted that there is still considerable duplication of effort by various county agencies. Countywide strategy sessions reportedly are being held to move toward further unification of the ITC service plans with IEP and other agency plans.

- In addition to the wraparound teams, several efforts are made by care coordinators to coordinate service provision among the various agencies, organizations, and providers, including regular contact with team members between meetings, attendance at IEP and other agency meetings, rotating location of team meetings, circulating the written service plans, and getting release forms from families. In addition, community team meetings are convened when necessary to break through obstacles faced by wraparound teams. Obstacles to effective coordination include the difficulty in getting individuals to respond to telephone messages and the reluctance of some individuals to share information. Desire was expressed for more countywide commitment to the wrap process. It was said

that school policies and procedures sometimes make it hard to coordinate services, but that schools, juvenile justice, and mental health generally work well together. The more rigid bureaucracy and larger caseloads at DCFS often create obstacles for effective coordination with social workers.

- The care coordinator is considered central to the success of service transitions, although cooperation between the previous and current providers is also essential, and the parent partner provides key support to the process. The care coordinator or parent partner follows up with the family and providers after a transition is made and reports back to the team. Although transitions usually are conducted smoothly, respondents agreed that there is always need for better communication to make the process easier on the child and family.

- All agencies involved with a child and family's care routinely attend the Community Partners Committee review meetings, but no summary of the meeting is printed or disseminated to attendees because of confidentiality issues. However, a triplicate form is used during the meeting to identify tasks assigned and the individuals who agreed to follow up with those tasks. A copy of this form goes to the family, to the persons agreeing to perform the tasks, and to the committee Chair.

Remaining Challenges

- Although any private provider or non-agency organization involved in a child's care could refer a case for review, neither case review body has received such a request.

F. Accessible

Strengths at the Infrastructure Level

- During the past 18 months, CMHI has succeeded in eliminating financial barriers to accessing both traditional and nontraditional services. Both uninsured and privately insured children are able to receive services through CMHI, however, most are covered by Medicaid. All agencies have flexible funds and sliding-scale fees.

- CMHI has responded effectively to identified inadequacies in the service array. For example, a major effort was undertaken by the FAC to address respite care needs through community focus groups, and the COCAC is responding to recommendations from this committee. Therapeutic foster beds have increased through the DCS contract with CCS. To address concerns with access barriers for the uninsured, DCS and the RSN are looking at alternatives in the community including the development of a free community health clinic.

- Provider contracts are performance-based, requiring that at least 60 percent of service hours be provided in the community, i.e., outside of the office environment. Most providers have flexible hours and convenient locations available to accommodate family

needs. Many services are provided in the home. All families have crisis plans in place, so they know whom to contact any time of day or night and how to contact them.

- Efforts to assess the accessibility of services have come primarily through the work of the RSN's Quality Management Committee. A variety of methods such as focus groups, interviews, consumer satisfaction assessments, access and availability of provider services (time frames to get into care, network utilization rates, follow up after hospitalization) is used to determine access to services. Findings from these efforts indicated the need for better service flexibility. As a result, provider contracts were modified. In another instance, focus group data revealed a need for defining transition protocols among agency providers. Complaint and grievance systems also are being put into place to help determine actual and potential access barriers.

Strengths at the Service Delivery Level

- Several efforts to reach out to the target community were reported by respondents, including quarterly public meetings targeted to community families and advertised in newspapers; 150 social marketing presentations in the community; brochures circulated through partner agencies and providers to children and families; and outreach to families through the schools at the beginning of each new school year. The Community Empowerment Project also contributes significantly to outreach. As a result of all these efforts, CMHI has increased the number of children and families served by 15 percent since the 2002 assessment. However, respondents agreed that many families who need services do not know about the program yet.

- From the family perspective, the intake process is not cumbersome, and families reported satisfaction with the flexibility and efficiency of the process. The time between referral and first service contact ranges between 60 minutes to 24 hours on most occasions, although this varies somewhat depending on which agency receives the referral. For Proviso, CCS, and IV–E, the first service planning meeting between the care coordinator and family generally takes place within a week, and the first team meeting is scheduled at that time. However, at the time of this assessment there was a waiting list for care coordinators (probation counselors) for the Connections program, which sometimes results in up to a 3-week wait for first contact.

- The majority of service planning meetings are reportedly held at the schools. They may also be held at juvenile court, another agency office, the family home, or elsewhere in the community if that is more convenient for the family. Most meetings are scheduled in the afternoon after school, but can be held in the evening if necessary to meet working family needs. During the summer, daytime meetings are common. Some schools allow flexible time to school personnel who need to attend evening meetings.

- Respondents reported that most services in the service array have sufficient capacity. However, concerns were expressed on the adequacy of some services, particularly intensive day treatment, therapeutic foster care and group home care, respite care, residential treatment, and inpatient hospitalization. Further concerns were noted about

services that frequently involve long waits of over 3 weeks, such as diagnostic and evaluation services, neurological or neuro-psychological assessment, and medication management.

- Care coordinators work flexible hours and usually can be reached by cellular telephone or pager. When they are unavailable, someone can always be reached in accordance with the family's crisis plan. Although care coordinators at the schools generally work 5 days per week from 9:00–5:00, others may work 8:00–5:00 on 4 days, plus evening and occasionally weekend hours. Depending on the agency where housed, parent partners may work traditional office hours with occasional evenings, whereas CCS parent partners work frequent weekends and evening hours. Care coordinators and parent partners meet with families at any suitable location that the family prefers, including schools, homes, juvenile court, other agencies, or elsewhere in the community. Therapists also are available for some evening appointments, with CCS therapists commonly providing late evening and weekend services as needed by children in intensive wraparound services.

- Transportation assistance reportedly is made available to families in a variety of forms, including gas vouchers, bus passes, assistance with car repairs, county van for disabled individuals, and direct rides by staff or paraprofessionals. Assistance has not included cash for parking meters. Public transportation services are limited to the city of Vancouver and do not serve other parts of the county, so transportation assistance is important for many families. Transportation assistance generally can be provided to each family a few times initially, but some children and families have difficulty if they need consistent assistance to reach weekly services, such as recreational activities.

- Respondents agreed that there rarely are any financial barriers to accessing needed services. Even for families with private insurance, CMHI will help with co-payments if needed, especially for counseling or alcohol and drug treatment.

Remaining Challenges

- Family advocates noted that it will be much more difficult for families who are uninsured and not covered by Medicaid to receive coverage in the future. When the grant ends, the County will be able to provide flexible funds only for those on Medicaid, and advocates noted that Medicaid does not cover some of the more nontraditional services that families need. Connections will not be affected because it has access to funds through juvenile justice dollars.

- According to grant staff, families do not always understand why they cannot access some of the wraparound programs that are reported to be successful, such as Connections, because they are not eligible. Parent partners have been added to facilitate better communication of available services that can meet their needs.

- The Community Partners Committee will accommodate evening meeting times if that is essential for a family's need, but meetings routinely are held at the DCS office downtown.

G. Community Based and Least Restrictive

Strengths at the Infrastructure Level

- Clark County offers an extensive array of traditional and nontraditional services within the community. Again, contracts require that services be provided in the community.

- Agency providers, grant staff, and families all receive training on the use of least restrictive community-based care.

- Philosophically, DCS does not believe that children and families should be served outside of their home communities, therefore policy decisions are driven by how best children can be served in their home and local area. This has been one of the most challenging and, in some cases, contentious issues for agency staff in working with DCS. While agency providers strongly support the use of least restrictive and community-based options, they stated that the resources and services must be available in order to access them. This is evident in situations where children are in custody or need substance abuse treatment programs. Respondents suggested that judges might be more lenient if the services were available or had minimal wait times.

Strengths at the Service Delivery Level

- Even though all services in the array are available within Clark County, staff reported a shortage of inpatient hospitalization and residential treatment services. For example, there is no residential center for girls in the county, so girls must travel as far as Bellingham, Washington (a 4-hour drive) to access such services. Most other out-of-county services are accessed either a few minutes away in Portland, Oregon, or 2–3 hours away in Seattle.

- Respondents agreed that the Community Partners Committee is dedicated to exploring and locating community-based and least restrictive service options for all children and families whose case situations are reviewed. The intensive, around-the-clock services provided by Catholic Community Services and CMOT help assure that needed services can be delivered within the community.

- When children are placed in more restrictive settings, wraparound teams continue to meet to discuss their situations, note progress made, and discuss ways to help them successfully transition to less restrictive settings as soon as possible. They have significant input into transitions out of restrictive school settings and out of some residential treatment centers. Once in detention, the youth must complete the assigned period, but the team is active in helping prepare for the transition out of detention back into the home, when the time comes. Teams reportedly have exercised creativity in finding suitable step-down settings, such as moving a child from a residential facility to live with an aunt. It was mentioned that intermediate settings between detention and the home—such as a halfway house, therapeutic group home, or therapeutic foster care—would be helpful services to add to the array.

- CLIP reviews cases in which restrictive placements are being considered. Procedures are in place to bring all parties together to exhaust less restrictive options before more restrictive placement are made, as well as to transition children being served in overly restrictive settings.

Remaining Challenges

- The quality monitoring program and the Community Partners Program review the number of children served outside of the community, and tracks them using a "restrictiveness of living environment" scale. Data show a marked decrease in the number of children placed outside of Clark County. It was not clear to staff, however, whether this information has been used to improve the service delivery system.

V. Sustainability and Lessons Learned

The Clark County Department of Community Services (DCS) continues to communicate a clear vision for sustaining a community of care for children and families who need mental health services.

Faced with significant reductions in funding at the State-level due to an estimated $3 billion State budget deficit in the 2003–2004 legislative session, DCS has made frequent trips to Olympia, the State capitol, to speak of the need to reduce system fragmentation and categorical funding as a means of not only reducing administrative costs, but also in lessening barriers to access to care for children and families. Staff reported that the legislative response has been favorable. Statewide legislation now supports system-of-care values and principles.

Clark County continues to undergo a major redesign of its children's mental health system in order to develop an infrastructure for improving flexibility, integration, cost effectiveness, and community voice. During the past 18 months, from an infrastructure perspective, these changes have included a restructuring of the governing body with new bylaws, expanding and enhancing the service array, "localizing" the evaluation and quality monitoring process, creating performance-based system-of-care language within its provider contracts, and continuing to integrate staff and administrative processes. In addition, the CMHI has produced provider standards for cultural competency and instituting new venues for capturing family and youth voice through such vehicles as the FAC, the Community Empowerment Project, the Youth Foundation and youth task forces. The service delivery system, on the other hand, has remained relatively stable as reflected in the comments from respondents.

Sustainability of the CMHI is promising, as data demonstrates a decrease in enrollment in the Children's Long-Term Inpatient Program and a decrease in hospital admissions, since the integration of system-of-care principles into the Clark County RSN. Of all counties in the State, Clark County currently has the lowest number of children being served in long-term care facilities.

A challenge the CMHI faces in moving forward will be how it uses data to further enhance philosophical, cultural, and regulatory change within child-serving agencies, the goal being better child and family outcomes and more creative funding arrangements. Decategorized funding and looking at new ways to maximize revenues will be especially important as the RSN moves to an all Medicaid payer mix, where flexible funds to support the needs of the non-Medicaid population will be eliminated.

Lessons Learned

It is possible to sustain an interagency collaborative system of care for a 5-year period. Although there have been major struggles along the way, partnering agencies and other providers have continued to meet together for dialogue and to collaborate on service provision. Partners believe that this process has helped them develop a higher respect for the value of collaboration efforts. The establishment of an advisory council with representatives from involved agencies, organizations, providers, and families has been a major factor in successful CMHI collaboration efforts.

Respondents identified concerns for the future of interagency collaboration, including how to keep all council members actively involved and contributing financially, how to increase school district involvement, how to increase the family voice in governance, how to further extend interagency collaboration throughout the system, and how to convince Federal agencies to provide the tools needed to decategorize funds locally.

It is possible to implement system-of-care changes within specific agencies and within the child-serving system at large. Participants believe that implementation of the Clark County CMHI has influenced practice at the various public agencies, including making providers more welcoming to families and contributing flexible funds for individualized services. The development of wraparound structures within various agencies and provider organizations has demonstrated this capacity for change.

Furthermore, counselors and administrators in the schools are now aware of a broader array of available services and are accessing these services for children and families. At juvenile justice, the Connections program provides services to children and families at flexible hours, including evenings and weekends. And at DCFS, caseworkers now view the family as a necessary partner for effective service coordination.

Respondents identified concerns for the future of system change related to the challenges of coordination efforts and shared decisionmaking required of care coordinators, the high short-term cost of staff-intensive system-of-care implementation, and the need for ongoing training in wraparound procedures due to high staff turnover.

It is possible to develop effective family involvement within a system of care. In Clark County, the establishment of the Community Empowerment Project and development of a parent partner pool to serve in a variety of settings have been instrumental in maximizing family voice throughout the system.

One concern identified for the future of family involvement was that a decrease in funds might result in converting paid parent partner positions into volunteer positions.

*Before attempting to implement a system of care, partners would be wise to carefully study past successes and failures in the local community's service system and to evaluate the commitment to sustain new programs.*Respondents noted that it generally proves counterproductive to view a system-of-care grant as a source of money for current programs, as agencies that take this approach will be unlikely to commit to long-term financial sustainability.

Respondents advised that local advocates for systems of care should avoid approaching the community with the assumption that they know what the problems are and how to solve them. Systemic change takes a long time to develop, as people from differing perspectives must learn to listen to each other and to trust one another. Likewise, they should avoid hiring consultants unfamiliar with the community to direct their change efforts.

CMHS National Evaluation
System-of Care Assessment Scores

Clark County, WA
September 29–October 1, 2003
Assessment #3

	OVERALL AVERAGE	Infrastructure Domain					Service Delivery Domain				
		Governance	Management and Operations	Service Array	Quality Monitoring	INFRA-STRUCUTRE AVERAGE	Entry into Service System	Service Planning	Service Provision	Case Review Structure	SERVICE DELIVERY AVERAGE
Family Focused	**4.39**	4.71	4.38		3.33	**4.26**	5.00	4.48	4.34	4.56	**4.46**
Individualized	**4.05**		4.33	4.20	3.50	**4.00**		4.23	4.38	1.00	**4.06**
Culturally Competent	**3.57**		3.50	2.33	3.75	**3.07**	2.25	4.00	4.25		**3.75**
Interagency	**3.60**	3.79	3.21		3.33	**3.48**	4.25	4.07		3.29	**3.81**
Collaborative/ Coordinated	**3.71**		4.39		4.00	**4.35**	4.00	3.38	3.68	3.20	**3.50**
Accessible	**4.04**		3.83	3.86	4.00	**3.87**	4.00	4.50	4.29	2.75	**4.07**
Community Based	**4.37**			4.25	3.00	**4.07**			4.55	4.50	**4.54**
Least Restrictive	**4.42**		4.40		3.50	**4.25**			4.40	5.00	**4.57**